JAMHI Health & Wellness, Inc.

JAMHI Intake Packet

General Information

Name (first, middle, last)		Preferred name
Social Security number	**Sex (legal)**	**Date of birth**
	☐Female ☐Male ☐Nonbinary/X ☐Other	

Mailing address: PO box or street	Mailing address: City, state, and zip code

Cell phone number	Alternate phone number	Email address

Do you need an interpreter?	Do you need an American Language (ASL) interpreter?	What is your preferred language (if other than English)
☐ Yes ☐ No	☐ Yes ☐ No	

Do you have any of the following impairments?

☐ Hearing ☐ Vision ☐ Speech ☐ Other: _____

Marital status

☐ Divorced ☐ Married ☐ Single - never married

☐ Domestic partner/ Cohabitating ☐ Decline to answer ☐ Unknown

☐ Legally separated ☐ Other: _____ ☐ Widowed

Ethnicity

- ☐ Cuban
- ☐ Mexican, Mexican American, or Chicano/a
- ☐ Puerto Rican
- ☐ Another Hispanic, Latino/a, or Spanish origin
- ☐ Not Hispanic, Latino/a, or Spanish origin
- ☐ Choose not to disclose
- ☐ Unknown

Race (check all that apply)

- ☐ American Indian
- ☐ Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Hmong
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ Samoan
- ☐ White/Caucasian
- ☐ Choose not to disclose
- ☐ Unknown
- ☐ Other:

Sexual Orientation and Gender

Sexual orientation

☐ Heterosexual (or straight) ☐ Bisexual ☐ Something else

☐ Don't know ☐ Choose not to disclose ☐ Gay

☐ Lesbian ☐ Unknown ☐ Asexual

☐ Pansexual ☐ Queer

Gender

☐ Female ☐ Intersex ☐ Other:_____

☐ Transgender woman/transfeminine ☐ Agender

☐ Male ☐ Genderfluid

☐ Transgender man/transmasculine ☐ Nonbinary

☐ Genderqueer ☐ Choose not to disclose

☐Two spirit ☐ Uncertain

Sex assigned at birth

- ☐ Female
- ☐ Male
- ☐ Intersex
- ☐ Not recorded on birth certificate
- ☐ Choose not to disclose
- ☐ Uncertain

Pronouns

- ☐ She/her/hers
- ☐ He/him/his
- ☐ They/them/theirs
- ☐ Decline to answer
- ☐ Unknown
- ☐ Your name

Employment Status (check all that apply)

- ☐ Disabled
- ☐ Active-duty military
- ☐ Self-employed
- ☐ Other: _____
- ☐ Full-time
- ☐ Part-time
- ☐ Student (full-time)
- ☐ Not employed
- ☐ Retired
- ☐ Student (part-time)

Emergency Contact

Note: *We are not authorized to release your protected health information without your authorization.*

Emergency contact name (first and last)	Relationship to patient
Emergency contact phone number	**Emergency contact notes**

Veteran Status

- ☐ Not a veteran
- ☐ Reservist
- ☐ Choose not to answer
- ☐ Active-duty military
- ☐ Veteran (prior service)
- ☐ Relative of veteran Relationship Type: _____
- ☐ National Guard
- ☐ Veteran (retired)

Guarantor

Note: *The guarantor is responsible for the charges associated with the account. For example, if the patient is a child, the child's parent or guardian is the guarantor.*

Who is the guarantor for this account?

- ☐ Self
- ☐ Patient's parent/guardian
- ☐ Other:
- ☐ Patient's spouse

Guarantor name (if not self)	Guarantor date of birth

Insurance (write "none" if not insured)

Primary insurance company	Subscriber/policyholder name
Patient's relationship to subscriber/policyholder (e.g. self, spouse, child, etc.)	Subscriber/policyholder identification number

Secondary insurance company	Subscriber/policyholder name
Patient's relationship to subscriber/policyholder (e.g. self, spouse, child, etc.)	Subscriber/policyholder identification number

Sliding Fee Discount Program Eligibility

Note: *These questions help us identify patients who may qualify for discounted services at JAMHI*

How many people are in your household?	What is your household's estimated annual income?
	$

What is your estimated household annual income? (If amount not entered above.)

- ☐ Less than $27,000 per year
- ☐ Approximately $27,000 per year
- ☐ Approximately $36,000 per year
- ☐ Approximately $46,000 per year
- ☐ Approximately $56,000 per year
- ☐ More than $75,000 per year

Would you like to apply for JAMHI's Sliding Fee Discount Program? ☐ Yes ☐ No ☐ I don't know

JAMHI provides combined medical care and behavioral health services. The information below take better care of you. Your medical, social, and behavioral health information all matter. You do have to answer any questions you do not want to share. But the more you feel comfortable sharing, better we can help you live your own best life.

Medical History – check all that apply

BH Medical History

- ☐ Abuse as Adult (victim)
- ☐ Alcohol Use Disorder
- ☐ Autism
- ☐ Depression
- ☐ Oppositional Defiance Disorder
- ☐ Mental Health Disorder
- ☐ Self-Injurious Behavior
- ☐ Homicidal Ideation
- ☐ Abuse as Child (victim)
- ☐ Anorexia Nervosa
- ☐ Body Dysmorphic Disorder
- ☐ Food Deprivation
- ☐ Previous Psych Hospital Admission
- ☐ History of Psychosis
- ☐ Substance Use Disorder
- ☐ Violent Behavior
- ☐ ADHD
- ☐ Anxiety
- ☐ Bulimia Nervosa
- ☐ Inadequate Housing
- ☐ Panic disorder
- ☐ PTSD
- ☐ Suicidal Ideation

Psychiatric Medical History

- ☐ Serotonin Syndrome
- ☐ Extrapyramidal Symptoms (EPS)
- ☐ Neuroleptic Malignant Syndrome (NMS)
- ☐ Tardive Dyskinesia (TD)

Past Medical History

- ☐ AIDS /HIV
- ☐ Bronchitis - chronic
- ☐ Gout
- ☐ Kidney Disease
- ☐ Prostate Problem
- ☐ Anemia
- ☐ Cancer
- ☐ Heart Disease
- ☐ Liver Disease
- ☐ Ulcers
- ☐ Arthritis
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Pneumonia
- ☐ Stroke
- ☐ Asthma
- ☐ Emphysema
- ☐ Herpes
- ☐ Pacemaker
- ☐ Thyroid Problems
- ☐ Bleeding Disorders
- ☐ Epilepsy
- ☐ High Blood Pressure
- ☐ Multiple Sclerosis
- ☐ Tuberculosis

☐ Other: _____

Surgical History (general, gender affirming)

☐ None

Type	Month/Year	Type	Month/Year

Family History – indicate if any relatives had any of the medical issues listed above.

Relation	Age	Current state of mental health	Case of death	Medical/Behavioral Health Issues
Father				
Mother				
Sibling				

Living Situation

☐ Private Residence ☐ Homeless ☐ Correction/Detention Facility ☐ Hospital, psych
☐ Shelter ☐ Foster Care ☐ Crisis Residence ☐ Hospital, non-psych
☐ Residential Treatment ☐ Therapeutic Foster Care ☐ Assisted Living Facility ☐ Nursing Home
☐ Halfway House ☐ Group Home

Referral Information

Where did you hear about JAMHI/who referred you?

☐ Medical Provider ☐ Behavioral Health Provider ☐ Hospital/ED ☐ School ☐ Court
☐ Word of Mouth ☐ Search Engine ☐ Social Media ☐ Other: _____

_____ _____
Printed Name Date

_____ _____
Signature Relationship to Patient

Authorization and Agreement for Treatment

About JAMHI Services and CCBHC Program

Through a grant from the Federal Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), JAMHI Health & Wellness, Inc. (JAMHI) has established a Certified Community Behavioral Health Clinic (CCBHC) in Juneau. The purpose of the CCBHC is to provide patient-centered integrated services, including access to crisis intervention services 24/7 for individuals with serious mental illness (SMI), substance use disorders (SUD), or co-occurring mental health and substance use disorders (COD); including children and adolescents with serious emotional disturbance (SED). JAMHI's CCBHC services are based out of 3406 Glacier Hwy, Juneau, AK 99801.

What you should expect

JAMHI is required by SAMHSA to collect information from individuals who receive services at out CCBHC. The information collected is only to help us show that our CCBHC providing you with effective services. If you choose to receive services at the CCBHC, you will be asked to provide confidential information, which we will not share directly with SAMHSA or anyone else in any way that identifies you. Your participation will be strictly confidential and voluntary. The reports that we create will combine your personal information with others in the program so that no one individual will be able to be identified.

Some data will be collected for everyone who receives a service with our CCBHC, and some persons will be randomly selected for additional health data collection. For those who are randomly selected for additional data collection, we will collect health data at intake, 6 months, and at discharge. Your appointments with the CCBHC program will be regularly scheduled. For those who are randomly selected for additional data collection, you will receive a small incentive for your participation in helping us obtain this data at the 6 month mark.

What you should know

Since JAMHI is only reporting on combined data from all participants collectively, it is highly unlikely that any reports required to be provided to SAMHSA or the State of Alaska as a result of you receiving CCBHC services will in any in any way identify specific persons participating in the program. As will all medical information and medical records, we are committed to protecting your privacy. Furthermore, information gathered in the course of your participation is stored in secure locations that only selected individuals are permitted to access.

Consent for Treatment

I consent to treatment at JAMHI. This may include receiving an assessment/evaluation or other new client appointment for behavioral health, psychiatric, and/or primary medical care. The type and extent of services that I will receive will be up to me and my providers. These services may include Primary Medical Care, Psychiatric Medication Management, Case Management, Individual Therapy, Group Therapy, Medications for Opioid Use Disorder, or Wellness. This may also include periodic Treatment Plan Reviews.

I will be separately informed by my provider about my proposed treatment or medication if prescribed as well as alternatives. I understand that I have the right to ask questions about the proposed treatment, the right to make decisions about my plan of care, the right to refuse services or care, and the right to obtain information about my health needs and treatment at JAMHI.

I understand that I have the right to sign a release of information at any time, or revoke a release of information at any time. I understand that limited circumstances allow for communication without a release of information:

- When there is known or suspected risk of imminent danger to myself or another person
- When there is known or suspected abuse/neglect
- When authorized by a special court order
- In a medical/psychiatric emergency

I understand that JAMHI staff communicates internally regarding my diagnosis, treatment recommendations, and progress.

I understand that I will not hold JAMHI staff and Board of Directors liable for any and all claims and demands for loss arising from my involvement with JAMHI supervised activities.

Communication by phone and unencrypted email or text messages

I consent to receive calls or unencrypted text messages/emails from JAMHI relating to my care. I understand there are risks with the use of unencrypted emails or text messages involving messages being intercepted, changed, forwarded, reviewed, or stored without my permission. I understand that JAMHI is not responsible for the confidentiality or security of messages after they have been sent from JAMHI. I understand that I may be charged a fee from my cellular phone service or internet provider for messages. I understand that I can opt out of receiving text, email, or phone communication from JAMHI.

No information regarding contact information will be shared with others outside of JAMHI.

I have read and understood the information above about calls, texts, and emails. I agree that JAMHI may use my phone number or email address to contact me.

Weapons and Drug Free Clinics

JAMHI is committed to providing all individuals a safe place to receive care. Therefore, JAMHI does not allow the following items to be brought into facilities: weapons, illegal drugs, alcohol, and drug paraphernalia are not allowed to be brought into JAMHI facilities. I understand that I am not allowed to bring these items into JAMHI, and if I do, I may be asked to leave. I understand that if I do not want to enter JAMHI facilities without these items, I may ask for a telehealth appointment instead of coming to the clinic for my appointment.

I have read, understand, and agree to the above and I agree to receive treatment at JAMHI.

_____ _____

Signature Date

_____ _____

Guardian Signature (if applicable) Date

Notice of Privacy Practices to JAMHI Clients

This notice describes how medical, drug, and alcohol related information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

General Information

Information regarding your health care, including payment for health care, is protected by three federal laws: the Health Insurance Portability and Accountability Act of 1996 (HIPAA), HITECH Act, 42 U.S.C. §1320d *et seq*., 45 CFR Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. § 290dd-2, 42 CFR Part 2. Under these laws, JAMHI may not generally disclose: 1) that you are a client to any person outside JAMHI, 2) any information identifying you as an alcohol or drug client, or 3) any other protected information except as permitted by federal law.

Generally, you must also sign a written consent before JAMHI can share information for treatment purposes or for health care operations. For example, JAMHI must obtain your written consent before it can disclose information to a provider outside of JAMHI who is also providing you with care, or when it needs to disclose information to your health insurer in order to be paid for services. Disclosures for health care operations could include disclosures to outside consultants to determine how to improve JAMHI services. All of these disclosures would require your written consent. However, federal law permits JAMHI to disclose information without your written permission:

- Pursuant to an agreement with a qualified service organization/business associate
- For audit and evaluations
- To report a crime committed on JAMHI premises or against JAMHI personnel
- To medical personnel in a medical/psychiatric emergency
- To appropriate authorities to report suspected child abuse or neglect
- As allowed by a court order

Before JAMHI can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing. Records that are disclosed to a Part 2 program, covered entity, or business associate pursuant to the patient's written consent may be further disclosed by that Part 2 program, covered entity, or business associate, without the patient's written consent, to the extent the HIPAA regulations permit such disclosure.

Your Rights

- You have the right to request a copy of your record by hard copy, fax or electronic media *except* under conditions listed below.
- Your authorization is required and that authorization may be revoked for 1) uses and disclosures of PHI for marketing purposes, 2) disclosure that constitutes a sale of PHI, 3) any use or disclosure other than those contained in this notice and 4) fundraising purposes. The uses and disclosures noted above are in the law but JAMHI does not engage in these practices.
- You have the right to request that we communicate with you by alternative means or at an alternate location. JAMHI will accommodate such requests that are reasonable and will not request an explanation from you.

- Under HIPAA and HITECH you also have the right to inspect and copy your own health information maintained by JAMHI, *except to the extent that the information contains psychotherapy notes, SUD notes, or information compiled for use in a civil, criminal, or administrative proceeding or in other limited circumstances.*
- You have the right to request the restriction of disclosure of PHI to a health plan or other insurer, when the PHI relates solely to a healthcare item or service where the client has paid for the item or service completely out of pocket (self-pay). Other than those services, you have the right to request restriction of information, but JAMHI is not required to agree to any restrictions you request, but if it does agree to them it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical/psychiatric emergency. 2 of 4

- Under HIPAA you also have the right to request an amendment of health care information maintained in JAMHI's records. JAMHI does not have to comply with your request, but if it does not, you will be permitted to provide a statement of disagreement to be included with your record.

- You have the right to request and receive an accounting of disclosures of your health-related information made by JAMHI during the seven years prior to your request.
- You also have a right to receive a paper copy of this notice.

JAMHI's Duties

JAMHI is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. JAMHI is required by law to abide by the terms of this notice. JAMHI reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. JAMHI is required to notify clients whose PHI has been involved in a breach.

Substance Use Information

FEDERAL LAW PROTECTS THE CONFIDENTIALITY OF CERTAIN SUBSTANCE USE DISORDER PATIENT RECORDS.

If you receive substance use treatment from a substance use treatment program at JAMHI, we may have records that are subject to substance use confidentiality laws (42 CFR Part 2 or Part 2). During those services, if any of your providers maintain treatment notes that are separated from your primary medical record, those notes may be withheld when other records are provided and may be requested separately.

You may provide a single consent for all uses and disclosures of both general PHI and substance use information. If you were mandated to treatment through the criminal legal system (including drug court, probation, or parole) and you sign a consent authorizing disclosures to elements of the criminal legal system such as the court, probation officers, parole officers, prosecutors, or other law enforcement, your right to revoke consent may be more limited and should be clearly explained on the consent you sign.

Records, or testimony relaying the content of such records, shall not be used or disclosed in any civil, administrative, criminal, or legislative proceedings against you unless based on your specific written consent or a court order. Records shall only be used or disclosed based on a court order after notice and an opportunity to hear is provided to you (the patient) and/or the holder of the record, where required by 42 USC § 290dd-2 and 42 CFR Part 2. A court order authorizing use or disclosure must be

accompanied by a subpoena or other similar legal mandate compelling disclosure before the record is used or disclosed.

If you believe that your substance use treatment records have been accessed or disclosed without your permission or in violation of the law, please file a complaint with our Privacy Officer or the HHS Office for Civil Rights, as described below.

Participation in Organized Health Care Arrangement and Health Information Exchange

JAMHI is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of JAMHI, OCHIN supplies information technology and related services to JAMHI and other OCHIN participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practice standards and assess clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your personal health information may be shared by JAMHI with other OCHIN participants or a health information exchange only when necessary for medical treatment or for the health care operations purposes of the organized health care arrangement. Health care operation can include, among other things, geocoding your residence location to improve the clinical benefits you receive.

The personal health information may include past, present, and future medical information as well as information outlined in the Privacy Rules. The information, to the extent disclosed, will be disclosed consistent with the HIPAA Privacy Rules or any other applicable law as amended from time to time. You have the right to change your mind and withdraw this consent; however, the information may have already been provided as allowed by you. This consent will remain in effect until revoked by you in writing. If requested, you will be provided a list of entities to which your information has been disclosed.

Complaints and Reporting Violations

If you believe your privacy rights have been violated, you have the right to file a complaint with the Secretary of the U.S. Department of Health and Human Services and JAMHI. You may do so by contacting the HHS Office for Civil Rights or accessing https://www.hhs.gov/hipaa/filing-a-complaint/index.html. You will not be retaliated against for filing such a complaint.

To file a complaint with JAMHI, the following name, address, and phone numbers are who you can make the report to:

Privacy Officer 3406
Glacier Hwy
Juneau, AK 99801
907-463-3303

For further information contact the Privacy Officer at JAMHI at the address and/or phone number listed above.

Effective Date: 04/20/2026

Acknowledgment

I hereby acknowledge that I received a copy of this notice. By signing below, I consent to my information being used and disclosed for treatment purposes and for health care operations in accordance with the information provided in the Notice of Privacy Practices. This consent will remain in place until I revoke my consent in writing or until the end of the record retention period that applies to my records after I conclude treatment with JAMHI, whichever is sooner.

Printed Name: _____

Signature Date:

Guardian Signature (if applicable): Date:

JAMHI
Health & Wellness, Inc.

Financial Responsibility

☐ JAMHI offers a sliding fee scale discount to income eligible clients for all services

By Accepting services at JAMHI Health & Wellness, Inc.:

- I accept financial responsibility for keeping my account current
- Payment is due in full at the time services are rendered
- Arrangements may be made in advance of services if payment can't be made at the time of services.
- It is my responsibility to inform JAMHI of any changes in my financial status.
- I am responsible for providing a Medicaid eligibility card.
- I am aware that I must provide accurate billing information.
- Failure of above may result in surcharges for retroactive billing and processing being applied.
- I understand my financial records may be released to a collection agency if my account becomes delinquent.
- I authorize the use of this form on all my insurance submissions.
- I authorize release of information from JAMHI to all my insurance companies for payment purposes.
- I understand that I am responsible for my bill or the portion not covered by my insurance company.
- I authorize JAMHI to act as my agent in helping me obtain payment from my insurance company.
- I authorize direct payment to JAMHI.
- I permit a copy of this authorization to be used in place of the original.
- I certify that I have been advised of and had explained to me JAMHI's package of services.
- I understand that I can revoke my authorization to release the information above by notifying my provider except to the extent that JAMHI has already acted in reliance upon my authorization. If I do not revoke my authorization, the records may be used or disclosed by the recipient and subject to redisclosure. This authorization is valid until JAMHI is paid in full for all treatment provided.

Signature _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____

What is JAMHI Health and Wellness?

JAMHI Health and Wellness (JAMHI) provides services for persons experiencing substance use, mental health and behavioral disorders, traumatic brain injury and developmental disabilities. In addition, we provide primary care treatment, wellness activities and pharmacy services.

Statement of Client Rights and Responsibilities

Your treatment and care is individualized and specific to you. We provide services in a welcoming, comprehensive, accessible manner to best meet your needs and consider you to be a valued member of your treatment team.

As a JAMHI client, I have a right to:

Basic Rights

- Be treated with respect and dignity.
- Receive services specific to me and my life.
- Be heard.
- Be safe.
- Participate in developing, reviewing and updating my treatment plan.
- View my client record, get a copy of my client record or have a copy of my client record sent directly to a third party within a reasonable timeframe.
- Receive information I need to make choices about services and programs available to me within the community and how to access those services.
- File a grievance if I feel I have been treated unfairly.
- Have rules, regulations, and information about my treatment explained in a way that I can understand.

Confidentiality

- Have all information about me handled confidentially. Exception: Information may be disclosed without consent under the following situations:
  - Known or suspected child abuse or neglect
  - Intent to commit suicide or homicide including warning of potential victim(s)
  - A medical or psychiatric emergency
  - To report a crime committed on JAMHI property or against JAMHI staff
  - If JAMHI receives a special court order requiring release
- Have my personal information shared only with those who need to know.

Consent for Sharing Your Information

- Sign a Release of Information form (ROI) so JAMHI can get or share information about me to assist in my treatment.
- Revoke the ROI if I choose to stop sharing information.

Care and Treatment

- Have access and referral to guardians, self-help groups, advocacy services, and legal services when available and necessary.
- Receive information about (including possible side effects) medications prescribed for me.
- Receive an explanation of charges and billings.
- Request a written summary of my treatment that includes discharge and transition plans.

As a JAMHI client my responsibilities are to:

- Actively participate in treatment including reviewing my treatment plan periodically (usually every 120 days).
- Inform staff of emotions, events, or commitments which may impact treatment.
- Maintain the confidentiality of other clients I may see at JAMHI facilities and activities.
- Be on time for appointments and give 24-hour notice if I cannot make an appointment.
- Provide health insurance information or financial information so JAMHI can determine if I qualify for reduced payment rates. If I choose not to provide this information, I will be responsible for payment of the full amount of services received.
- Appropriately communicate the needs I have while keeping myself and others safe.
- ***Understand that violence, threats, or verbal abuse are not tolerated and may result in discharge from JAMHI services.***

Signature

I have read, understand, and agree to the above statements.

Signature _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____

Client Grievance Policy & Procedure

JAMHI Health & Wellness, Inc. (JAMHI) provides an open, prompt, and responsive way for clients to voice concerns, or lodge a grievance about JAMHI, free from intimidation or retaliation. Grievances may be filed verbally (in person or telephonically) or in writing. Clients may designate a representative to advocate or assist in all stages of the grievance process. An advocate may be a JAMHI staff person, staff from an external agency (i.e. NAMI, Disability Law Center) or a friend or family member of the client's choosing. Grievances will be processed in accordance with Alaska state law and the procedures outlined in the State of Alaska Department of Health and Human Services, Behavioral Health division guidance (approved 6-18-2007) as reflected in this policy. Patient grievances are also addressed in accordance with the HRSA Compliance Manual, Chapter 10: Quality Improvement/Assurance. Grievances are one of the components JAMHI uses to gather data on satisfaction pf patient services.

PROCEDURE:

1. JAMHI supports open communication and encourages clients to speak to the staff person of concern, if the grievance involves actions taken or not taken by a staff person. If the client feels uncomfortable speaking with the staff person directly, the client may ask to speak with the supervisor of the staff person.
2. If that approach is unsatisfactory or the issue does not involve a specific staff person, clients may file a grievance. The grievance, whether verbal or written, should contain as much information as possible to assist in the investigation.
3. When submitting the grievance, the person serviced will have the option of waiving confidentiality for the limited purposes of investigating the grievance. Confidentiality of the person served will be maintained throughout the grievance investigation process unless the person served chooses to waive confidentiality.
4. Notification will be provided to the person served within five (5) business days after submitting the grievance that the process to investigate and resolve the grievance has begun.
5. JAMHI staff will investigate the grievance and the Compliance Officer or designee will respond back to the person served with the results of the investigation within 30 days of receipt of the grievance. If JAMHI is unable to reach resolution within 30 days, the person served will receive written notification. For grievances involving behavioral health services, if the grievance remains unresolved after 30 days, JAMHI will refer the matter to the state Division of Behavioral Health (within 5 business days of the grievance reaching the 30 day timeframe). Patient grievances unresolved after 30 days are referred to the CEO.
6. Grievances that involve alleged abuse, neglect, or unnecessary seclusion or restraint will be immediately elevated to the JAMHI Board for review.
7. If after receiving the response to the investigation the matter is not resolved to the satisfaction of the person served, they may request that the issue be reviewed by the CEO (Step 2 in Grievance process). The CEO will review the matter and issue a written summary of the resolution.
8. If after receiving the CEO's written response, the person served is still not satisfied, they may request that the matter be reviewed by a hearing committee of some of the Board of Directors (Step 3 in Grievance process). The Board's recommendation is final.
9. Documentation related to the grievance will be maintained in separate files for each grievance and stored in a secure location and not included within the clients' individual clinical files.

Acknowledgment

I hereby acknowledge that I received a copy of this notice.

Signature _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____

JAMHI
Health & Wellness, Inc.

Telemedicine Consent Form

Patient Name: _____ **DOB:** _____

Health care services are available by two-way interactive video communications and/or by the electronic transmission of information. Referred to as "telemedicine" or "telehealth", this means that I may be evaluated and treated by a health care provider or specialist from a different location. Since this is different than the type of consultation with which I am familiar, **I understand and agree to the following:**

1. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

2. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

3. I understand it is my responsibility to conduct my portion of the telemedicine visit from a secure and private area so that others do not see/hear my protected health information.

4. I understand that in the event the connection fails during my visit, my healthcare provider will call me and the visit will continue as a telephone visit.

5. I understand that I will receive my link to a telehealth appointment before at the time of my appointment via MyChart, text, or email and I can let JAMHI know my preference for receiving this information.

6. I understand that I have the following patient rights:
    a. To be treated with dignity, respect and courtesy without discrimination
    b. To have privacy concerning healthcare services
    c. To receive quality service
    d. To receive service from competent service providers
    e. To report concerns regarding service delivery to telehealth management
    f. To report concerns or file complaints with the medical board http://www.tmb.state.tx.us
    g. To self-determination and the right to accept risk
    h. To participate in decisions, state preferences and make choices regarding care/service i. To refuse intervention
    j. To make choices in personal lifestyle
    k. To maintain relationships with family and friends

7. I agree to notify my health care provider at the beginning of my telemedicine visit of the name and relationship of anyone else that will be present with me during my telemedicine visit.

8. I have had the alternatives to a telemedicine visit explained to me, and in choosing to participate in a telemedicine visit.

9. In an emergent situation, I understand that my telemedicine health care provider will advise my emergency contact and/or local emergency personnel (911).

10. I understand that billing will occur from my health care provider.

11. JAMHI and its staff are not liable for breaches in confidentiality caused by me not complying with these agreements.

I have read and fully understand the consent form. I understand the risks and benefits of telehealth services. I consent to participate in a telehealth visit under the conditions and instructions outlined, as well as any other instructions that my provider may impose to communicate with me electronically.

_____ _____

Signature Date

_____ _____

Guardian Signature (if applicable) Date

Patient Information and Acknowledgment

Access to Services

- Hours of operation and service locations, JAMHI is open 8:00 am – 4:30 pm Monday-Friday at the Salmon Creek Clinic for Adult Outpatient and all ages Primary Care Services.
- Emergency Services and a Nurse Line are available 24/7, by calling 907-463-3303. I will call 911 if I have an emergency.

Rules and Expectations

- I am expected to provide 24 hours of notice for cancelling an appointment, or my appointment will be marked as a No Show. I understand that this impacts my care and other patients' care when I miss an appointment without sufficient notice.
- I understand that if I would like to engage in telehealth services, I may, with a signed Telehealth Consent Form.

Health and Safety

- In the event of an emergency, I will follow instruction of the staff member that is around me to ensure I am safe, including exiting the building through emergency exits, giving space for emergency responders or staff, and otherwise not interfering with emergencies.
- I understand that JAMHI has security cameras (video only) in public spaces of their campuses, and other shared spaces like lobbies, parking lots, some hallways, entries, and other common areas. This is to maintain safety of me, other patients, and JAMHI staff and property.
- I understand that JAMHI is a weapon and substance free facility.
- I understand that JAMHI is a hands-free facility and does not practice seclusions or restraints. JAMHI utilizes a verbal de-escalation model, and I understand that there is zero tolerance for violence.
- I understand that JAMHI staff have a Duty to Warn and Protect obligation and requirement (safety-related disclosures) if they find a threat or plan to be credible to harm someone.
- I understand that all JAMHI staff are mandatory reports for vulnerable adults and all individuals under 18, which means if abuse, neglect, or exploitation is suspected that JAMHI staff are required to notify the proper state offices or authorities.

Course of Treatment

- I understand that JAMHI performs initial and comprehensive evaluations, and the providers will recommend treatment or services based off of that evaluation, updated information, my diagnoses, and my needs.
- I understand that as part of my treatment, JAMHI performs treatment planning that includes my input, collaboration with my other providers, and is consistently updates with any changes to my treatment.
- I understand that if I choose to receive treatment elsewhere, JAMHI will assist in ensuring my information is transitioned to the proper providers that I would like to have my records from JAMHI. I understand that JAMHI's discharge process initiates when I choose to no longer participate in JAMHI services, or I disengage from services. My record will be administratively discharged, but I will still have access to my records upon request.
- JAMHI's Client Handbook can be found on their website: https://www.jamhihealthandwellness.org/

Acknowledgment

By signing below, I acknowledge that:

- I have had the opportunity to ask questions
- I understand how to request additional information or clarification at any time

Printed Name: _____

_____ _____

Signature **Date**

_____ _____

Guardian Signature (if applicable) **Date**